RESOURCE REFERRALS

(Original to family, copy to patient file)

Date: _____ **Patient:** _____

City: _____

Health Services:

- ❑ Medi-Cal ❑ CHDP ❑ CCS MTU Services
- ❑ Mental Health ❑ Nutrition ❑ Oral Health
- ❑ Healthy Families ❑ CCS ❑ CCS Care
- ❑ GHPP ❑ Other:
- ❑ Specialty care: _____

Reason for referral: _____

Referral phone number(s): _____

Education Services:

- ❑ Head Start ❑ Special Education Services
- ❑ Other: _____

Reason for referral: _____

Referral phone number(s): _____

Developmental Services:

- ❑ Early Start ❑ Regional Center ❑ Vocational Rehab.
- ❑ Other: _____

Reason for referral: _____

Referral phone number(s): _____

Family Assistance Programs:

- ❑ TANF (AFDC) ❑ Food Stamps ❑ WIC
- ❑ SSI ❑ Housing ❑ Other
- ❑ Transportation services: _____

Reason for referral: _____

Referral phone number(s): _____

Support Programs:

- ❑ Family Voices ❑ LAUSD Parent Network ❑ Family Resource Centers
- ❑ Protection & Advocacy
- ❑ Support Group _____ (for specific conditio

Reason for referral: _____

Referral phone number(s): _____

Provider: _____

Phone Number: _____

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